January 1 – December 31, 2025

Evidence of Coverage for Employer Groups: Oklahoma State University (Basic)

Your Medicare Prescription Drug Coverage as a Member of Blue Cross Group MedicareRx (PDP)SM

This document gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-877-838-3833. (TTY users should call 711). We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. This call is free.

This plan, Blue Cross Group MedicareRx (PDP)SM, is offered by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Care Service Corporation (HCSC). When it says "plan" or "our plan," it means Blue Cross Group MedicareRx (PDP).)

Prescription drug plans provided by Blue Cross and Blue Shield of Oklahoma, which refers to Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HCSC's plans depends on contract renewal.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and BCBSOK, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association (the Association), permitting BCBSOK to use the Service Marks in the State, and that BCBSOK is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSOK and that no person, entity, or organization other than BCBSOK shall be held accountable or liable to Subscriber for any of BCBSOK's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSOK other than those obligations created under other provisions of this agreement.

This document is available for free in Spanish.

Please contact our Customer Service number at 1-877-838-3833 for additional information. (TTY users should call 711.) We are open 8 a.m. - 8 p.m., local time, 7

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OMB Approval 0938-1051 (Expires: August 31, 2026)

days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Calls to this number are free.

Para obtener más información por favor póngase en contacto con nuestro número de servicio al cliente en 1-877-838-3833. (Usuarios de TTY deben llamar al 711). El horario es de 8:00 – 20:00, hora de local, 7 días a la semana. Si usted está llamando desde el 1 de abril hasta el 30 de septiembre, tecnologías alternativas (por ejemplo, correo de voz) se utilizarán los fines de semana y festivos.

Please contact Blue Cross Group MedicareRx (PDP) if you need this information in another language or format (Spanish, braille, large print or alternate formats).

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2026.

The formulary and/or pharmacy network may change at any time. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Blue Cross Group MedicareRx (PDP), which is a Medicare Prescription Drug Plan

You are covered by Original Medicare or another health plan for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Blue Cross Group MedicareRx (PDP).

Blue Cross Group MedicareRx (PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered drugs* refer to the prescription drug coverage available to you as a member of Blue Cross Group MedicareRx (PDP).

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Blue Cross Group MedicareRx (PDP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Blue Cross Group MedicareRx (PDP) between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Blue Cross Group MedicareRx (PDP) after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Blue Cross Group MedicareRx (PDP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B. Section 2.2 tells you about Medicare Part A and Medicare Part B.)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area).

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Blue Cross Group MedicareRx (PDP)

Blue Cross Group MedicareRx (PDP) is available only to individuals who live in our plan service area.

Because your coverage is provided through a contract with your current or former employer or union, your plan has a national service area, defined as anywhere in

the United States. To remain a member of our plan, you must continue to reside in the national plan service area.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this document) to provide us with your new mailing address.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross Group MedicareRx (PDP) if you are not eligible to remain a member on this basis. Blue Cross Group MedicareRx (PDP) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card - Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

The *Pharmacy Directory* (bcbsok.com/retiree/medicare-tools) lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, you MAY have a pharmacy network that consists of both network pharmacies and preferred network pharmacies. Please contact your employer/union benefits administrator for more information about your plan benefits.

If you don't have the *Pharmacy Directory*, you can get a copy from Customer Service. You can also find this information on our Blue Access for Members (BAM) portal.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Blue Cross Group MedicareRx (PDP). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Blue Cross Group MedicareRx (PDP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the Blue Access for Members (BAM) portal or call Customer Service.

SECTION 4 Your monthly costs for Blue Cross Group MedicareRx (PDP)

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2025, the monthly premium for Blue Cross Group MedicareRx (PDP) is $116.90. For questions about premiums, enrollment, and eligibility, please contact your Member Services Center for Health and Insurance at 1-866-504-4256. Be sure to have your BEMSID and phone pin. If you have not created a phone pin, you will be routed to a representative to assist you with creating one. Hearing-impaired callers should use the relay service offered through their telephone service provider. Representatives are available Monday to Friday, 9 a.m. to 8 p.m. Eastern Time (8 a.m. to 7 p.m. Central Time; 7 a.m. to 6 p.m. Mountain Time; 6 a.m. to 5 p.m. Pacific Time).

Section 4.2 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in Blue Cross Group MedicareRx (PDP), we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for which you may be responsible and/or methods for paying your premium or Part D late enrollment penalty, please contact your employer/union benefits administrator.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA).

Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount is $36.78.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.1492. This rounds to $5.15. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.3 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 4.4 Medicare Prescription Payment Plan Amount

If you are participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your

monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 7 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty, there are several ways you can pay your penalty

For information regarding the amount of premium or Part D late enrollment penalty for which you may be responsible and/or methods for paying your premium or Part D late enrollment penalty, please contact your employer/union benefits administrator.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell your employer/union benefits administrator and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 Blue Cross Group MedicareRx (PDP) contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to Blue Cross Group MedicareRx (PDP) Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-877-838-3833 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
FAX	1-855-297-4245
WRITE	Customer Service P.O. Box 4555 Scranton, PA 18505

How to contact us when you are asking for a coverage decision or appeal

A coverage decision is a decision we make about your coverage or about the amount we will pay for your Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions and Appeals for Part D Prescription Drugs – Contact Information
CALL	1-877-838-3833 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
TTY	711 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
FAX	1-855-212-8110
WRITE	Blue Cross Group MedicareRx (PDP) Attn: Clinical Review Department 2900 Ames Crossing Road Eagan, MN 55121

How to contact us when you are making a complaint

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints – Contact Information
CALL	1-877-838-3833 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
TTY	711 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Method	Complaints – Contact Information
FAX	1-855-674-9189
WRITE	Blue Cross Medicare Advantage c/o Grievances P.O. Box 4288 Scranton, PA 18505
MEDICARE WEBSITE	You can submit a complaint about Blue Cross Group MedicareRx (PDP) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask the plan for reimbursement or to pay the pharmacy bill, see Chapter 5 *(Asking us to pay our share of the costs for covered drugs).*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Medical Claims Payment Request – Contact Information
WRITE	Medical Claims Payment Request P.O. Box 4195 Scranton, PA 18505

Method	Prescription Drug Payment Request – Contact Information
WRITE	Prescription Drugs Claims Payment Request P.O. Box 20970 Lehigh Valley, PA 18002-0970

Method	International Emergency/Urgent Care Payment Request – Contact Information
WRITE	Blue Cross Blue Shield Global Core Service Center P.O. Box 2048 Southeastern, PA 19399
WEBSITE	www.bcbsglobalcore.com

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.

<table>
<tr><th>Method</th><th>Medicare – Contact Information</th></tr>
<tr><td>WEBSITE (continued)</td><td>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:
Medicare Eligibility Tool: Provides Medicare eligibility status information.
Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.
You can also use the website to tell Medicare about any complaints you have about Blue Cross Group MedicareRx (PDP):
Tell Medicare about your complaint: You can submit a complaint about Blue Cross Group MedicareRx (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.
If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</td></tr>
</table>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. See the appendix in the back of this document to locate information for the SHIP in your state.

The State Health Insurance Assistance Program (SHIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:
• Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page) • Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. See the appendix in the back of this document for a list of Quality Improvement Organizations.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact the Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
WEBSITE	www.ssa.gov/

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI)**: Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency for your state listed in the appendix in the back of this document.

SECTION 7 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (https://www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible (if applicable), and prescription copayments and coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra

Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See the appendix in the back of this document for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Beneficiaries may contact our Customer Service Area to request assistance in obtaining Best Available Evidence (BAE) information and for providing this evidence.
- When you contact us, we will verify if there is a discrepancy and/or if we are able to resolve the discrepancy regarding your extra help based on the information to which we have access. In some cases, we may need to request you to provide documentation if you have it available. If you do not have documentation available, we will attempt to verify the status of your extra help through communication channels and in accordance with the guidance established by the Centers for Medicare and Medicaid Services (CMS).
- The documents listed below are valid for the purpose of establishing the correct level of extra help and effective date for individuals who should be deemed eligible for Low Income Subsidy (LIS). Each item listed below must show that the person was eligible for Medicaid during a month after June of the previous calendar year.
  - A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date
    - If the copy of the beneficiary's Medicaid card does not indicate an effective date, it will not be accepted as a form of BAE.
  - A copy of a State document that confirms active Medicaid status
  - A print-out from the State electronic enrollment file showing Medicaid status

  - A screen print from the State's Medicaid systems showing Medicaid status
  - Other documentation provided by the State showing Medicaid status
  - A letter from SSA showing that the individual receives SSI; or
  - An application Filed by Deemed Eligible confirming that the beneficiary is "...automatically eligible for Extra Help..."
- Part D sponsors are required to accept any one of the following forms of evidence from the beneficiary or the beneficiary's pharmacist, advocate, representative, family member or other individual acting on behalf of the beneficiary to establish that a beneficiary is institutionalized or, beginning on a date specified by the Secretary, but no earlier than January 1, 2012, is an individual receiving home and community-based services (HCBS) and qualifies for zero cost-sharing:
  1. A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
  2. A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;
  3. A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.
  4. Effective as of a date specified by the Secretary, but no earlier than January 1, 2012, a copy of:

     a) A State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;

     b) A State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

     c) A State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

d) Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year; or,

e) A state-issued document, such as a remittance advice, confirming payment for HCBS, including the beneficiary's name and the dates of HCBS

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program in your state.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-405-271-4000.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the AIDS Drug Assistance Program (ADAP) in your state listed in the appendix in the back of this document.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help"

from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan – Contact Information
CALL	1-877-838-3833 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Fax	1-440-557-6525
WRITE	Blue Cross Group MedicareRx (PDP) MPPP Election Dept. 13900 N. Harvey Ave Edmond, OK 73013 **Email:** ElectMPPP@RxPayments.com
WEBSITE	https://www.bcbsok.com/medicare/member/using-your-plan/medicare-prescription-payment-plan

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

See the appendix in the back of this booklet for a list of State Pharmaceutical Assistance Programs.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also

call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**.

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2025* handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.1 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.) Or you can fill your prescription through the plan's mail-order service.
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the Drug List for short). (See Section 3 in this chapter.)
- Your drug must be used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 of this chapter for more information about restrictions on your coverage.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term *covered drugs* means all of the Part D prescription drugs that are on the plan's Drug List.

Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, you MAY have a pharmacy network that consists of both network pharmacies and preferred network pharmacies. Please contact your employer/union benefits administrator for more information about your plan benefits.

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our Blue Access for Members (BAM) portal, and/or call Customer Service.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy. Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, you MAY have a pharmacy network that consists of both network pharmacies and preferred network pharmacies. Please contact your employer/ union benefits administrator for information about your plan benefits.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Customer Service or use the *Pharmacy Directory*. You can also find information in the Blue Access for Members (BAM) portal.

What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Pharmacy Directory* bcbsok.com/retiree/medicare-tools or call Customer Service.

Section 2.3 Using the plan's mail-order service

Your coverage is provided through a contract with your current or former employer or union. Please contact your employer/ union benefits administrator for information about your plan benefits.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get information about filling your prescriptions by mail, please contact one of our preferred mail-order pharmacies:

- Walgreens Mail Service, 24 hours a day, 7 days a week, at: 1-877-277-5475 (TTY: 711), or online at: www.walgreensmailservice.com.

- Express Scripts® Pharmacy, 24 hours a day, 7 days a week, at: 1-833-715-0944 (TTY: 711), or online at: express-scripts.com/rx.

- Amazon Pharmacy, 24 hours a day, 7 days a week, at: 1-855-393-4279 (TTY: 711), or online at: pharmacy.amazon.com.

See Chapter 4, Sections 5.2 and 5.4 for preferred and standard cost-sharing amounts at mail-order pharmacies.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 days. To refill your mail order prescriptions, please contact our mail-order services

10 to 20 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

- If a mail-order delay exists and you are in jeopardy of therapy interruption, your plan allows for mail delay override. Please call Customer Service to get an override approval. Once approval is received, the mail-order pharmacy will transfer your prescription to the pharmacy of your choice or have your prescriber telephone a shorter supply to a local retail pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions at any time by contacting your mail order pharmacy to set up automatic refills for your prescriptions.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by logging into your online account or by contacting the pharmacy directly.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by logging into your online account or by contacting the pharmacy directly.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each

refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by logging into your online account or by contacting the pharmacy directly.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Prime Therapeutics LLC, provides pharmacy benefit management services for Blue Cross and Blue Shield of Oklahoma and is owned by 19 Blue Cross and Blue Shield Plans, subsidiaries or affiliates of those plans.

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by Blue Cross and Blue Shield of Oklahoma (BCBSOK) to provide pharmacy benefit management services.

BCBSOK, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Walgreens Mail Service is contracted to provide pharmacy mail services to members Blue Cross Group MedicareRx (PDP).

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Oklahoma.

Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross Group MedicareRx (PDP).

Section 2.4 How can you get a long-term supply of drugs?

Your coverage is provided through a contract with your current or former employer or union. Please contact your employer/ union benefits administrator for information about your plan benefits.

The plan offers two ways to get a long-term supply (also called an *extended supply*) of *maintenance* drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* bcbsok.com/retiree/medicare-tools tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If the member is traveling outside his or her plan's service area and:
  - he/she runs out of or loses his or her covered Part D drugs; or
  - becomes ill and needs a covered Part D drug; or
  - cannot access a network pharmacy.
- If the member is unable to obtain a covered Part D drug in a timely manner within his or her service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24/7 service;

- If the member is filling a prescription for a covered Part D drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or mail-order pharmacy;
- If the member is provided with covered Part D drugs dispensed by an out-of-network institution-based pharmacy while the beneficiary is in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
- During any Federal disaster declaration or other public health emergency declaration in which Part D enrollees are evacuated or otherwise displaced from their place of residence and cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy. In addition, in circumstances in which normal distribution channels are unavailable.
- Refill prescriptions for routine or maintenance drugs filled at out-of-network pharmacies in a NON-emergency situation or unusual circumstances, will not be available for coverage under your Medicare Part D benefit.
- In addition, Blue Cross Group MedicareRx (PDP) will not routinely allow for more than a month's supply of medication to be dispensed at an out-of-network pharmacy, although Blue Cross Group MedicareRx (PDP) may override the one-month limit on a case-by-case basis when warranted by extraordinary circumstances.
- You can locate all of the Blue Cross Group MedicareRx (PDP) participating pharmacies in your area by calling the Pharmacy Locator line at 1-877-800-0746, answered 24 hours a day, 365 days a year. TTY users call 711, answered 24 hours a day, 365 days a year.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

The plan has a *List of Covered Drugs (Formulary).* In this *Evidence of Coverage*, **we call it the Drug List for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is used for a medically accepted indication. A *medically accepted indication* is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed, or.
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to *drugs*, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 10 for definitions of the types of drugs that may be on the Drug List.

What is ***not*** on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 7.)

Section 3.2 There are 5 cost-sharing tiers for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Tier 1** Preferred Generic (Lowest Tier)
- **Tier 2** Generic
- **Tier 3** Preferred Brand
- **Tier 4** Non-Preferred Drug
- **Tier 5** Specialty (Highest Tier)

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have 4 ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the Blue Access for Members (BAM) portal. The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (MyPrime.com or by calling Customer Service). With this tool you can search for drugs on the Drug List to see an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

Please note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (See Chapter 7.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan, based on specific criteria, before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. **If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.**
- **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.**

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an **exception** and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's Drug List** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

Circumstances exist in which unplanned transitions for current members could arise and in which prescribed drug regimens may not be on the Plan Sponsor's formulary. These circumstances usually involve level of care changes in which a member is changing from one treatment setting to another. For these unplanned transitions, members and prescribers must use our exceptions and appeals processes. Coverage determinations are processed and redeterminations are made as expeditiously as your health condition requires.

- In order to prevent a temporary gap in care when a member is discharged to home, members are permitted to have a full outpatient supply available to continue therapy once their limited supply provided at discharge is exhausted. This outpatient supply is available in advance of discharge from a Part A stay.
- When a member is admitted to or discharged from an LTC facility and does not have access to the remainder of the previously dispensed prescription, a one-time override of the "refill too soon" edits is processed for each medication which would be impacted due to a member being admitted to or discharged from a LTC facility. Early refill edits are not used to limit

appropriate and necessary access to a member's Part D benefit, and such members are allowed to access a refill upon admission or discharge.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's Drug List.

See Chapter 10 for definitions of the drug types discussed in this chapter.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug List that affect you during the current plan year

In order to immediately replace brand name drugs or biological products with, respectively, new therapeutically equivalent or new authorized generic drugs or new interchangeable biological products or new unbranded biological products (or to change the tiering or the restrictions, or both, applied if the related drug remains on the formulary), plan sponsors that otherwise meet the requirements must provide the following advance general notice of changes:

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice**.
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

  - We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We will tell you at least 30 days before we make the change, or tell you about the change and cover an 30-day fill of the version of the drug you are taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

Changes to the Drug List that do not affect you during the current plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other changes noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are *excluded*. This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. Contact your employer/union benefits administrator for more information about your plan benefits. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans: (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)

- Non-prescription drugs (also called over-the-counter drugs)

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the appendix in the back of this document.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to**

reimburse you for our share. See Chapter 5, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility?

If you are admitted to a hospital or to a skilled nursing facility, Original Medicare (or your Medicare health plan with Part A and B coverage, if applicable) will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* bcbsok.com/retiree/medicare-tools to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in Blue Cross Group MedicareRx (PDP) doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Blue Cross Group MedicareRx (PDP) in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist

or provider will determine whether to bill Medicare Part B or Blue Cross Group MedicareRx (PDP) for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is creditable, and the choices you have for drug coverage. (If the coverage from the Medigap policy is creditable, it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You’ll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You’ll also get a medication list that will include all the medications you’re taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It’s a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program please contact Customer Service.

CHAPTER 4:
What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the LIS Rider. (Phone numbers for Customer Service are printed on the back cover of this document.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 3, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time", meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Customer Service.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called *cost sharing*, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost of the drug you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Your coverage is provided through a contract with your current or former employer or union. Please contact your employer/union benefits administrator for information about your plan benefits.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Blue Cross Group MedicareRx (PDP) members?

There are three **drug payment stages** for your prescription drug coverage under Blue Cross Group MedicareRx (PDP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the *Part D EOB*)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. This includes what you paid when you get a covered Part D drug, any

payments for your drugs made by family or friends, and any payments made for your drugs by “Extra Help” from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called *year-to-date* information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Here are examples of when you should give us copies of your drug receipts:**

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports. You can also sign up to receive the Part D Explanation of Benefits summary online instead of by mail.
  - To sign up, log onto MyPrime.com
  - Click on the drop down arrow next to your name.
  - Select Communication Preferences.
  - Check the Email box.
  - Click Save.

If you change your mind and want to receive your EOB by mail again, you can update your communication preference at MyPrime.com. Be sure to keep these reports.

SECTION 4 There is no deductible for Blue Cross Group MedicareRx (PDP)

There is no deductible for Blue Cross Group MedicareRx (PDP). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 5 cost-sharing tiers

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1** Preferred Generic (Lowest Tier)
- **Tier 2** Generic
- **Tier 3** Preferred Brand

  You pay $35 per month supply of each covered insulin product on this tier.

- **Tier 4** Non-Preferred Drug

  You pay $35 per month supply of each covered insulin product on this tier.

- **Tier 5** Specialty (Highest Tier)

  You pay $35 per month supply of each covered insulin product on this tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 and the plan's *Pharmacy Directory*.

Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, you MAY have a pharmacy network that consists of both network pharmacies and preferred network pharmacies. Please contact the employer/union benefits administrator for information about your plan benefits.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier. Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in network)** (up to a 30-day supply)	**Standard Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$6	$6	$6	$6
Cost-Sharing Tier 2 (Generic)	$6	$6	$6	$6
Cost-Sharing Tier 3 (Preferred Brand)	$38	$38	$38	$38
Cost-Sharing Tier 4 (Non-Preferred Drug)	$68	$68	$68	$68
Cost-Sharing Tier 5 (Specialty)	30%	30%	30%	30%

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost sharing tier.

Please see Section 7 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the *daily cost-sharing rate*) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an *extended supply*). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply)	Mail-order cost sharing (in-network) (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$15	$15
Cost-Sharing Tier 2 (Generic)	$15	$15
Cost-Sharing Tier 3 (Preferred Brand)	$95	$95
Cost-Sharing Tier 4 (Non-Preferred Drug)	$170	$170
Cost-Sharing Tier 5 (Specialty)	30%	30%

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,000. You then move on to the Catastrophic Coverage Stage.

The *Part D EOB* that you receive will help you keep track of how much you the plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,000 out-of-pocket limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's Drug List or contact Customer Service for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost, by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself.

- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration. (If you get "Extra Help," we will reimburse you for this difference.)

Section 7.1 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccination are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this document.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using provided and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 5:
Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Sometimes when you get a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan, or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's Drug List or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out of pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this document.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records. **You must submit your claim to us within 36 months** of the date you received the service, item, or drug.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.bcbsok.com/retiree-medicare-tools) or call Customer Service and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

Prescription Drug Claims Payment Request
PO Box 20970
Lehigh Valley, PA 18002-0970

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in Spanish, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Blue Cross Group MedicareRx (PDP) at 1-877-838-3833. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Nuestro plan cuenta con servicios de intérpretes gratuitos disponibles para responder preguntas de miembros discapacitados y de aquellos que no hablan inglés. También podemos brindarle información en sistema braille, en español, en letra grande o en formatos alternativos de forma gratuita si lo requiere. Debemos brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nuestra parte de una manera que la pueda comprender, llame al Departamento de Servicios para Miembros (los números de teléfono están impresos en la contraportada de este documento).

Nuestra aseguradora cuenta con personas y servicios gratuitos de interpretación para responder preguntas de asegurados con alguna discapacidad o que no hablen inglés. Si lo necesita, también podemos proporcionarle sin costo información en braille, en letra grande u otros formatos. Tenemos la obligación de proporcionarle información sobre los beneficios de la cobertura en un formato accesible, eficaz y

apropiado para usted. Comuníquese con Atención al Miembro para recibir información en un formato eficaz para usted (los números telefónicos aparecen en la contraportada de este folleto).

Si tiene dificultades para acceder a la información sobre nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar un reclamo ante Blue Cross Group MedicareRx (PDP) al 1-877-838-3833. También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o puede presentarla directamente en la Oficina de Derechos Civiles. La información de contacto está incluida en esta Evidencia de Cobertura, o puede comunicarse al 1-800-368-1019 o TTY 1-800-537-7697 para acceder a información adicional.

Section 1.2 We must ensure that you get timely access to your covered drugs

You have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your *personal health information* includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective 10/01/2022

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is committed to protecting your privacy and understands the importance of safeguarding medical information. We are required by the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of your protected health information (PHI) that identifies you or could be used to identify you. HIPAA also requires that we provide you this Notice of Privacy Practices which explains our legal duties, our privacy practices and your rights regarding the PHI that BCBSOK collects and maintains about you. In addition, state law requires that we provide you a state notice that explains how BCBSOK can use or disclose your nonpublic personal financial information and describes your rights regarding this information.

To receive this notice electronically, go to the Blue Access for MembersSM (BAMSM) portal at BCBSOK.com and sign up.

This section explains the RIGHTS you have regarding your PHI and our obligations regarding these rights. You can exercise these rights by submitting a written request to us – the contact information is at the end of this notice.
Right to request an amendment to your PHI • You can request an amendment to your PHI in a designated record if you believe it is incorrect or incomplete. • We have 60 days to respond to your request, however, we can receive an additional 30-days if needed. • We can deny your request, for example if we determine that your PHI is correct and complete or that we did not create the PHI. We will explain the reason for the denial in the response we send you and you have a right to submit a statement of disagreement.
Right to request confidential communications • You can request that we contact you in a specific way or at an alternative address. • We are required to accommodate reasonable requests; however, we do have the right to ask you for information about how your payment will be handled as well as specifics about your communication alternatives.

Right to request a list of individuals or entities who received your PHI

- You can request an accounting of disclosures which is a list of all the disclosures we made during the six years prior to your request date. The list will not contain all disclosures made for treatment, payment, health care operations as well as a couple of other situations (details about these situations are described later in the notice).
- You can request 1 accounting in any 12-month period - if you request additional ones in this time frame, we may charge a reasonable cost-based fee. We will notify you before charging you - you can then withdraw or modify your request to avoid a fee.
- We have 60 days to respond to your request; however, we have an additional 30 days if needed.

Right to request a copy of the Notice

- You can request a paper copy of this notice at any time. To request a copy, submit your written request using the contact information at the end of this notice.

Right to choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, this individual can act on your behalf and make choices for you.
- We will confirm that this individual has the right to act on your behalf before we release any of your PHI.

Right to file a complaint

- You can file a complaint directly with us if you believe we have violated your privacy rights by using the contact information at the end of this notice.
- You can also file a complaint with the Secretary of U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at:
  200 Independence Ave., SW, Washington, D.C. 20201.
- We will not retaliate against you in any way for filing a complaint.

This section explains when we must receive your consent before sharing your PHI.

We can share your PHI for these purposes with your verbal or written consent.

- You can identify a relative, close friend, or other person to help you with your care decisions; we will disclose limited PHI needed to that person to assist you. (If you are unable to give your consent and we determine in our professional judgement that it is in your best interest, we can use or disclose your PHI to assist in notifying a family member, personal representative or other person that can help you.)
- For our fundraising efforts.

We cannot use or disclose PHI for these purposes without your written consent.

- To conduct marketing or for our financial benefit
- Release psychotherapy notes

  There may be other uses and disclosures of your PHI beyond those listed that may require your authorization if the use or disclosure is not permitted or required by law.

  You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

This section describes the situations where we are permitted by federal laws to use or share your PHI.

Although not exhaustive, it will give you a good idea of the types of routine uses and disclosures we make.

Manage and support the health care you receive

- We can use your PHI and share it with the health professionals who are treating you, for example, when your provider sends us information about your diagnosis and treatment plan so we can arrange for additional services.

Run our organization

- We can use and disclose your PHI to help us manage our business operations and fulfill our obligations to our customers and members, for example, we use PHI for enrollment, health care programs, activities related to the creation, renewal, or replacement of a health plan, and development of better high quality healthcare services. (We can’t use genetic information to deny or refuse an individual health plan coverage).

Pay for your health services

- We can use and disclose your health information to process your claims and pay your provider, for example, when we share information about you to coordinate benefits between your dental plan and our medical plan.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration purposes, for example, if your company contracts with us to provide their group health plan, we may need to provide them certain statistics to explain the premiums we charge.

The following are examples of when we are permitted to use or disclose your PHI without authorization and without your ability to object to its use or disclosure.

Public health activities

- We are permitted to disclose PHI for public health purposes. This includes disclosures to a public health authority or other government agency that has the authority to collect and receive such information (e.g., the Food and Drug Administration).

Health oversight activities

- We can use or disclose your PHI to the extent that it is required by federal, state, or local laws for health oversight.

Abuse, neglect, or serious threat to health or safety

- We can disclose PHI to a government agency or public health authority authorized by law to receive information about adults and children who are victims of abuse, neglect, or domestic violence.
- We also can disclose PHI, if in our professional opinion it is necessary to prevent a serious and imminent threat to the public health or safety; however, the PHI can only be disclosed to someone that we reasonably believe can prevent or lessen the threat.

Research Initiatives

- In certain situations, we are permitted to disclose a limited data set for research purposes.

Required by the Secretary of Health and Human Services

- We may be required to disclose PHI to the Secretary of Health and Human Services so that they can determine our compliance with the requirements of the final rule related to the Standards for Privacy of Individually Identifiable Health Information.

Comply with the law

- In some situations, we may be required by applicable federal, state, or local law to disclose your PHI.

Organ donors, coroners and funeral directors

- If you are an organ donor, we may disclose your PHI to an organ procurement organization if needed to facilitate organ donation or transplantation.
- We may disclose your PHI if it is needed by a medical examiner, coroner or funeral director to perform legally authorized duties.

Workers' Compensation

- We may be required to share PHI to comply with workers compensation laws and other similar programs.

Specialized Government Functions; National Security and Intelligence Activities

- We may be asked to disclose PHI in certain situations such as determining eligibility for benefits offered by the Department of Veterans Affairs.
- We may also be required by law to disclose PHI to authorized federal officials for national security concerns, intelligence or counterintelligence activities, the protection of the President, and other authorized persons or foreign heads of state as may be required by law.

Respond to lawsuits and legal actions

- We may disclose your PHI in response to an administrative or court order but only if the disclosure is expressly authorized.
- We may also be required to disclose PHI to respond to a subpoena, discovery request, or other similar request.

Law enforcement

- We may disclose PHI, if the applicable legal requirements are met, to law enforcement for the purposes of responding to a crime.

Inmates

- We may use or disclose the PHI we created or received in the course of paying for the healthcare services of inmates in a correctional facility.

Business Associates

- We may disclose PHI to a Business Associate which is an entity or person that performs activities or services on our behalf that involve the use, disclosure, access, creation, or storage of PHI. We require a Business Associate to execute appropriate agreements before they initiate these activities or services.

Additional Health information

- Some federal or state laws include additional requirements for the use or disclosure of certain health condition related information. We follow the applicable requirements of these laws.

We also have the following responsibilities and legal obligations to:

- Maintain the privacy and security of your PHI.
- Notify you in the event you are affected by a breach of unsecured PHI.
- Provide you a paper copy of this notice upon request.
- Abide by the terms of this current notice.
- Refrain from using or disclosing PHI in any manner not described in this notice unless you authorize us to do so in writing.

STATE PRIVACY NOTICE

Effective 10/01/2022

Blue Cross and Blue Shield of Oklahoma (BCBSOK) collects nonpublic personal information about you from your insurance application, healthcare claims, payment information and consumer reporting agencies. BCBSOK will:

- **Not** disclose this information, even if your customer relationship with us ends, to any non-affiliated third parties except with your consent or as permitted by law.
- **Restrict** access to this information to only those employees who perform functions necessary to administer our business and provide services to our customers.
- **Maintain** security and privacy practices that include physical, technical, and administrative safeguards to protect this information from unauthorized access.
- **Use** this information for the sole purpose of administering your insurance plan, processing your claims, ensuring proper billing, providing you with customer service and complying with the law.
- **Only** share this information as required or permitted by law and if needed with the following third parties:
  - Company affiliates
  - Business partners that provide services on our behalf (i.e., claims management, marketing, clinical support
  - Insurance brokers or agents, financial services firms, stop-loss carriers
  - Regulatory, governmental and law enforcement agencies
  - Your Employer Group Health plan.

You also have the right to ask what nonpublic financial information we have about you and to request a copy of it.

CHANGES TO THESE NOTICES

We reserve the right to change the privacy practices described in these notices and make the new practices apply to all the PHI we maintain about you. Should we make a change, we will post the revised notices on our website. You can always

request a paper copy using the contact information below. Depending on the changes made to the Notice, we may be required by applicable law to mail you a copy.

CONTACT INFORMATION FOR THESE NOTICES

If you would like general information about your privacy rights or would like a copy of these notices, go to: http://www.BCBSOK.com/legal-and-privacy/privacy-notice-and-forms. If you have any questions about this Notice or want to exercise a right described in the Notice, you can contact us by:

Calling: The toll-free number located on your member identification card or 1-877-361-7594.

Writing: Executive Director,
Privacy Office
Blue Cross and Blue Shield of Oklahoma
300 East Randolph Street
Chicago, IL 60601-5099

REVIEWED: August 2024

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of Blue Cross Group MedicareRx (PDP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this document):

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network pharmacies.** You have the right to get information about the qualifications of the pharmacies in our network and how we pay the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a Part D drug is not covered or if your coverage is restricted. Chapter 7

also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with a state-specific agency such as a State Health Insurance Assistance Program (SHIP) or Quality Improvement Organization (QIO). Please refer to the appendix in the back of this document for contact information.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are printed on the back cover of this document).
- You can **call the SHIP**. For details, go to the appendix in the back of this document.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are printed on the back cover of this document).
- You can **call the SHIP**. For details, go to the appendix in the back of this document.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections.* (The publication is available at: https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.

- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask and get an answer you can understand.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums (if applicable).
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this document).
  - Because your coverage is provided through a contract with your current or former employer or union, your plan service area is defined as anywhere in the United States.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you** cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this document.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7:
What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful—and sometimes quite important—for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Customer Service for help. But in some situations, you

may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in the appendix in the back of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether prescription drugs are covered or not, the way they are covered, and problems related to payment for prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, Customer Service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for prescription drugs, including payments. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can *appeal* the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or *fast appeal* of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Part D appeals are discussed further in Section 5 of this chapter). If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written

notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

This section is about your Part D drugs only. To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**

- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first) **Ask for an exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. (Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, tiering exceptions may not be applicable to your plan. Please contact your employer/union benefits administrator for more information about your plan benefits.) **Ask for an exception. Section 5.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an *exception*. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in a designated Tier. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug (Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, tiering exceptions may not be applicable to your plan. Please contact your employer/union benefits administrator for more information about your plan benefits.).

2. **Removing a restriction for a covered drug**. Chapter 3 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug. Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, tiering exceptions may not be applicable to your plan. Please contact your employer/union benefits administrator for more information about your plan benefits.

    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (Specialty).
    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called *alternative* drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm. Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, tiering exceptions may not be applicable to your plan. Please contact your employer/union benefits administrator for more information about your plan benefits.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A *fast coverage decision* is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

<u>Step 2:</u> Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* which is available on our website getblueok.com/pdp/plandocs. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the *supporting statement*,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A *fast appeal* is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a *fast appeal*.
- The requirements for getting a *fast appeal* are the same as those for getting a *fast coverage decision* in Section 5.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request.** Chapter 2 has contact information.

- **For fast appeals either submit your appeal in writing or call us at 1-877-838-3833.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website getblueok.com/pdp/plandocs. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 5.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the *independent review organization* is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a *fast appeal*.
- If the organization agrees to give you a *fast appeal*, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug, you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must **provide the drug coverage** that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the** independent review organization says yes to part or all of your request to pay you back **for a drug you already bought, we are required to** send payment to you within 30 calendar days **after we receive the decision from the review organization.**

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called *upholding the decision*. It is also called *turning down your appeal*.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal **An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

Section 7.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the Customer Service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Customer Service or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint

Legal Terms
• A **Complaint** is also called a **grievance.** • **Making a complaint** is also called **filing a grievance.** • **Using the process for complaints** is also called **using the process for filing a grievance.** • A **fast complaint** is also called an **expedited grievance.**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Grievances received verbally will be responded to in writing, unless you request a verbal response.
- Although we may verbally contact you to discuss your grievance and/or the resolution, grievances received in writing will be responded to in writing.
- Grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing, including a description of your right to file a written complaint with the Quality Improvement Organization (QIO).
- All grievances (verbal and written), will be responded to within the following timeframes:
  - Standard Grievances (any complaint other than an expedited grievance defined above) will be responded to as expeditiously as your case requires, based on your health status, but no later than 30 days after receipt of your grievance. Blue Cross Group MedicareRx (PDP) may extend the 30-day timeframe by up to 14 days if either you request the extension or if Blue Cross Group MedicareRx (PDP) determines additional information is needed and that the delay is in your best

interest. If there is a delay, Blue Cross Group MedicareRx (PDP) will notify you in writing of the reason for the delay.

- Expedited Grievances may only be filed if Blue Cross Group MedicareRx (PDP) denies your request for an expedited coverage determination or expedited redetermination. Expedited Grievances will be responded to within 24 hours.

- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a *fast coverage decision* or a *fast appeal*, we will automatically give you a *fast complaint*.** If you have a *fast complaint*, it means we will give you an answer **within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Blue Cross Group MedicareRx (PDP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Blue Cross Group MedicareRx (PDP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during your group's Annual Open Enrollment period

You can end your membership in our plan during your group's Annual Open Enrollment period. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **Check with your employer/group administrator to understand the group's Annual Open Enrollment Period.**
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare prescription drug plan,
  - Original Medicare *with* a separate Medicare prescription drug plan,
  - Original Medicare *without* a separate Medicare prescription drug plan,
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.

If you enroll in most Medicare health plans, you will be disenrolled from Blue Cross Group MedicareRx (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Blue Cross Group MedicareRx (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Blue Cross Group MedicareRx (PDP) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples; for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - If you have moved out of your plan's service area
  - If you have Medicaid
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions
  - If we violate our contract with you
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
  - **Note**: If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.
- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week.

TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare prescription drug plan,
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
- If you enroll in most Medicare health plans, you will automatically be disenrolled from Blue Cross Group MedicareRx (PDP) when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Blue Cross Group MedicareRx (PDP) for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan. Your coverage is provided through a contract with your current employer or former employer or union. Please contact your employer/union benefits administrator for more information.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. • You will automatically be disenrolled from Blue Cross Group MedicareRx (PDP) when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from Blue Cross Group MedicareRx (PDP) when your new plan's coverage begins. • However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep Blue Cross Group MedicareRx (PDP) for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Customer Service if you need more information on how to do this) or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).
• Original Medicare *without* a separate Medicare	• **Send us a written request to disenroll** or visit our website to disenroll online. Contact Customer Service if you need more information on how to do this.

If you would like to switch from our plan to:	This is what you should do:
prescription drug plan.	• You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan.

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

SECTION 5 Blue Cross Group MedicareRx (PDP) must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Blue Cross Group MedicareRx (PDP) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area. (Because your coverage is provided through a contract with your current or former employer or union, your plan has a national service area, defined as anywhere in the United States. To remain a member of our plan, you must continue to reside in the national plan service area.)
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.

- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
  - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Blue Cross Group MedicareRx (PDP) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or can make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Blue Cross Group MedicareRx (PDP), as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 10:
Definitions of important words

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,000 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for prescription drugs.

Complaint – The formal name for *making a complaint* is *filing a grievance*. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium, if applicable.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed *copayment* amount that a plan requires when a specific drug is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called *coverage decisions* in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – A *daily cost-sharing rate* may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your *daily cost-sharing rate* is $1 per day.

Deductible – The amount you must pay for prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a *generic* drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for *cost sharing* above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's *out-of-pocket* cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Service Area – A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy. (Your coverage is provided through a contract with your current or former employer or union. Depending upon the plan design from your employer, you MAY have a pharmacy network that consists of both network pharmacies and preferred network pharmacies. Please contact your employer/union benefits administrator for more information about your plan benefits.)

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

State Health Insurance Assistance Programs (SHIPs)

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	State Health Insurance Assistance Program	201 Monroe Street, Suite 350	Montgomery, AL 36104	1-800-243-5463 TTY: 711	http://www.alabamaageline.gov
Alaska	Alaska State Health Insurance Assistance Program	550 W. 8th Avenue	Anchorage, AK 99501	1-800-478-6065 TTY: 1-800-770-8973	https://health.alaska.gov/dsds/Pages/medicare/ship.aspx
Arizona	Arizona State Health Insurance Assistance Program	1789 W Jefferson Street, Site Code 950A	Phoenix, AZ 85007	1-800-432-4040 TTY: 711	https://des.az.gov
Arkansas	Senior Health Insurance Information Program	1 Commerce Way	Little Rock, AR 72202	1-800-224-6330 TTY: 711	https://insurance.arkansas.gov/pages/consumer-services/senior-health/
California	Health Insurance Counseling & Advocacy Program (HICAP)	1300 National Drive, Suite 200	Sacramento, CA 95834	1-800-434-0222 TTY: 711	https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/
Colorado	State Health Insurance Assistance Program	1560 Broadway, Suite 850	Denver, CO 80202	1-888-696-7213 TTY: 711	https://www.colorado.gov/dora/seniorhealthcare-medicare

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Connecticut	CHOICES	55 Farmington Avenue, 12th Floor	Hartford, CT 06105	1-800-537-2549 TTY: 1-800-842-4524	https://portal.ct.gov/AgingAndDisability
Delaware	Delaware Medicare Assistance Bureau	841 Silver Lake Boulevard	Dover, DE 19904	1-800-336-9500 TTY: 711	https://insurance.delaware.gov/divisions/dmab/
District of Columbia	Health Insurance Counseling Project (HICP)	Dept. of Aging and Community Living 500 K Street NE	Washington, DC 20002	1-202-724-5626 TTY: 711	https://dcoa.dc.gov/service/dc-state-healthinsurance-assistanceprogram-ship
Florida	Serving Health Insurance Needs of Elders (SHINE)	4040 Esplanade Way, Suite 270	Tallahassee, FL 32399	1-800-963-5337 TTY: 1-800-955-8771	http://www.floridashine.org/
Georgia	Georgia SHIP	2 Peachtree Street, NW, Suite 33-101	Atlanta, GA 30303	1-866-552-4464 TTY: 711	https://aging.georgia.gov/georgia-ship
Hawaii	Hawaii State Health Insurance Assistance Program	250 S Hotel Street, Suite 406	Honolulu, HI 96813	1-888-875-9229 TTY: 1-866-810-4379	https://hawaiiship.org/
Idaho	Senior Health Insurance Benefits Advisors (SHIBA)	700 West State Street, P.O. Box 83720	Boise, ID 83720	1-800-247-4422 TTY: 711	https://doi.idaho.gov/shiba/

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Illinois	Senior Health Insurance Program	320 W Washington Street, 5th Floor	Springfield, IL 62767	1-800-252-8966 TTY: 1-888-206-1327	https://www2.illinois.gov/aging/ship/Pages/default.aspx
Indiana	State Health Insurance Assistance Program	311 W. Washington Street, Suite 300	Indianapolis, IN 46204-2787	1-800-452-4800 TTY: 1-866-846-0139	https://www.in.gov/ship/index.htm
Iowa	Senior Health Insurance Information Program	601 Locust Street, 4th Floor	Des Moines, IA 50309	1-800-351-4664 TTY: 1-800-735-2942	https://shiip.iowa.gov/
Kansas	Senior Health Insurance Counseling for Kansas (SHICK)	503 South Kansas Avenue	Topeka KS 66603-3404	1-800-860-5260 TTY: 711	https://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs
Kentucky	State Health Insurance Assistance Program	275 E. Main Street, 3E-E	Frankfort, KY 40621	1-877-293-7447 TTY: 1-888-642-1137	https://chfs.ky.gov/agencies/dail/Pages/ship.aspx
Louisiana	State Health Insurance Assistance Program	P.O. Box 94214	Baton Rouge, LA 70804	1-800-259-5300 TTY: 711	https://ldi.la.gov/consumers/senior-health-shiip

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Maine	Maine State Health Insurance Assistance Program	41 Anthony Avenue	Augusta, ME 04333	1-800-262-2232 TTY: 1-800-606-0215	https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance
Maryland	State Health Insurance Assistance Program	301 W Preston Street, Suite 1007	Baltimore, MD 21201	1-800-243-3425 TTY: 1-800-637-4113	https://aging.maryland.gov/Pages/state-health-insurance-program.aspx
Massachusetts	Serving the Health Insurance Needs of Everyone (SHINE)	1 Ashburton Place, 5th Floor	Boston, MA 02108	1-800-243-4636 TTY: 1-800-610-0241	https://www.mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program
Michigan	Medicare/Medicaid Assistance Program (MMAP)	6105 W St. Joseph Highway, Suite 204	Lansing, MI 48917	1-800-803-7174 TTY: 711	http://mmapinc.org/
Minnesota	Senior LinkAge Line	540 Cedar Street, P.O. Box 64976	Saint Paul, MN 55164	1-800-333-2433 TTY: 711	https://mn.gov/senior-linkage-line/

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Mississippi	State Health Insurance Assistance Program	200 South Lamar Street	Jackson, MS 39201	1-800-948-3090 TTY: 711	https://www.shiphelp.org/about-medicare/regional-ship-location/mississippi
Missouri	CLAIM	200 North Keene Street, Suite 101	Columbia, MO 65201	1-800-390-3330 TTY: 711	https://www.missouriclaim.org/
Montana	State Health Insurance Assistance Program	2030 11th Avenue, P.O. Box 4210	Helena, MT 59604	1-800-551-3191 TTY: 711	https://dphhs.mt.gov/SLTC/aging/SHIP
Nebraska	Senior Health Insurance Information Program	1526 K Street, Suite 201	Lincoln, NE 68508	1-800-234-7119 TTY: 1-800-833-7352	https://doi.nebraska.gov/ship-smp
Nevada	State Health Insurance Assistance Program	3416 Goni Road, Suite D-132	Carson City, NV 89706	1-800-307-4444 TTY: 711	https://adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/
New Hampshire	ServiceLink Resource Center	Gallen State Office Park, 129 Pleasant Street	Concord, NH 03301	1-866-634-9412 TTY: 1-800-735-2964	https://www.servicelink.nh.gov/medicare/index.htm

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
New Jersey	State Health Insurance Assistance Program	P.O. Box 807	Trenton, NJ 08625	1-800-792-8820 TTY: 711	https://www.nj.gov/humanservices/doas/services/q-z/ship/index.shtml
New Mexico	New Mexico ADRC	2550 Cerrillos Road	Santa Fe, NM 87505	1-800-432-2080 TTY: 1-505-476-4937	http://www.nmaging.state.nm.us/
New York	Health Insurance Information Counseling and Assistance Program (HIICAP)	2 Empire State Plaza, Agency Bldg. #2, 4th Floor	Albany, NY 12223	1-800-701-0501 TTY: 711	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap
North Carolina	Seniors' Health Insurance Information Program	325 N. Salisbury Street	Raleigh, NC 27603	1-855-408-1212 TTY: 1-800-735-2962	https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
North Dakota	State Health Insurance Counseling (SHIC)	600 East Blvd, State Capitol, Dept 401	Bismarck, ND 58505	1-888-575-6611 TTY: 1-800-366-6888	https://www.insurance.nd.gov/shic-medicare
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP)	50 West Town Street, 3rd Floor, Suite 300	Columbus, OH 43215	1-800-686-1578 TTY: 1-614-644-3745	https://insurance.ohio.gov/about-t-

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					us/divisions/oshiip
Oklahoma	Oklahoma Senior Health Insurance Counseling Program	400 NE 50th Street	Oklahoma City, OK 73105	1-800-763-2828 TTY: 711	https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/
Oregon	Senior Health Insurance Benefits Assistance (SHIBA)	P.O Box 14480	Salem, OR 97309	1-800-722-4134 TTY: 711	https://healthcare.oregon.gov/shiba/pages/index.aspx
Pennsylvania	PA MEDI	555 Walnut Street, 5th Floor	Harrisburg, PA 17101	1-800-783-7067 TTY: 711	https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx
Rhode Island	Senior Health Insurance Program	Office of Healthy Aging 25 Howard Ave, Building 57	Cranston, RI 02920	1-401-462-3000 TTY: 1-401-462-0740	https://oha.ri.gov/Medicare

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
South Carolina	Insurance Counseling Assistance and Referrals for Elders (I-CARE)	1301 Gervais Street., Suite 350	Columbia, SC 29202	1-800-868-9095 TTY: 711	https://aging.sc.gov/
South Dakota	Senior Health Information & Insurance Education (SHIINE)	Center for Active Generations, 700 Governors Drive	Pierre, SD 57501	1-877-331-4834 TTY: 711	http://shiine.net/
Tennessee	State Health Insurance Assistance Program	502 Deaderick Street, 9th Floor	Nashville, TN 37243-0860	1-877-801-0044 TTY: 711	https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html
Texas	Health Information Counseling and Advocacy Program (HICAP)	701 West 51st Street, MC: W352	Austin, TX 78751	1-800-252-9240 TTY: 1-800-735-2989	https://www.hhs.texas.gov/services/health/medicare
Utah	Senior Health Insurance Information Program	195 North 1950 West	Salt Lake City, UT 84116	1-800-541-7735 TTY: 711	https://daas.utah.gov/seniors/
Vermont	The Vermont State Health Insurance	HC 2 South 280 State Drive	Waterbury, VT 05671-2070	1-800-642-5119 TTY: 711	https://asd.vermont.gov/services/ship

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Assistance Program				
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP)	1610 Forest Avenue, Suite 100	Richmond, VA 23229	1-800-552-3402 TTY: 711	https://www.vda.virginia.gov/vicap.htm
Washington	Statewide Health Insurance Benefits Advisors (SHIBA)	5000 Capital Boulevard SE	Tumwater, WA 98501	1-800-562-6900 TTY: 1-360-586-0241	https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
West Virginia	West Virginia State Health Insurance Assistance Program	1900 Kanawha Boulevard, E, 3rd Floor	Charleston, WV 25305	1-877-987-4463 TTY: 711	http://www.wvship.org/
Wisconsin	State Health Insurance Assistance Program	1 West Wilson Street	Madison, WI 53703	1-800-242-1060 TTY: 1-888-758-6049	https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
Wyoming	Wyoming State Health Insurance	106 West Adams Avenue	Riverton, WY 82001	1-800-856-4398 TTY: 711	https://www.wyomingseniors.com/services/wyoming-state-health-

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Information Program				insurance-information-program

Quality Improvement Organization (QIOs)

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee	Acentra Health	5201 West Kennedy Blvd. Suite 900	Tampa, FL 33609	1-888-317-0751 TTY: 711	https://www.acentraqio.com/
Alaska Idaho Oregon Washington	Acentra Health	5201 West Kennedy Blvd. Suite 900	Tampa, FL 33609	1-888-305-6759 TTY: 711	https://www.acentraqio.com/
Arizona California Hawaii Nevada	Livanta BFCC-QIO Program	10820 Guilford Road, Suite 202	Annapolis Junction, MD 20701	1-877-588-1123 TTY: 1-855-887-6668	https://livantaqio.com/en
Arkansas Louisiana New Mexico Oklahoma Texas	Acentra Health	5201 West Kennedy Blvd. Suite 900	Tampa, FL 33609	1-888-315-0636 TTY: 711	https://www.acentraqio.com/

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Colorado Montana North Dakota South Dakota Utah Wyoming	Acentra Health	5201 West Kennedy Blvd. Suite 900	Tampa, FL 33609	1-888-317-0891 TTY: 711	https://www.acentraqio.com/
Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	Acentra Health	5201 West Kennedy Blvd. Suite 900	Tampa, FL 33609	1-888-319-8452 TTY: 711	https://www.acentraqio.com/
Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia	Livanta BFCC-QIO Program	10820 Guilford Road, Suite 202	Annapolis Junction, MD 20701	1-888-396-4646 TTY:1-888-985-266	https://livantaqio.com/en
Illinois Indiana Michigan Minnesota Ohio Wisconsin	Livanta BFCC-QIO Program	10820 Guilford Road, Suite 202	Annapolis Junction, MD 20701	1-888-524-9900 TTY: 1-888-985-8775	https://livantaqio.com/en
Iowa Kansas Missouri Nebraska	Livanta BFCC-QIO Program	10820 Guilford Road, Suite 202	Annapolis Junction, MD 20701	1-888-755-5580 TTY: 1-888-985-9295	https://livantaqio.com/en

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
New Jersey New York Puerto Rico Virgin Islands	Livanta BFCC-QIO Program	10820 Guilford Road, Suite 202	Annapolis Junction, MD 20701	1-866-815-5440 TTY: 1-866-868-2289	https://livantaqio.com/en

Medicaid State Agencies

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	Alabama Medicaid Agency	501 Dexter Avenue, P.O. Box 5624	Montgomery, AL 36104	1-800-362-1504 TTY: 711 8 am - 5 pm CST	https://medicaid.alabama.gov/
Alaska	Alaska Department of Health and Social Services	3601 C Street, Suite 902	Anchorage, AK 99503-5923	1-800-770-5650 TTY: 1-907-586-4265 8 am - 5 pm AKST	http://dhss.alaska.gov/Pages/default.aspx
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	801 E. Jefferson Street, MD 4100	Phoenix, AZ 85034	1-800-654-8713 TTY: 1-800-842-6520 8 am - 5 pm MST	https://www.azahcccs.gov/
Arkansas	Arkansas Department of Human Services	Donaghey Plaza, P.O. Box 1437 - slot S401	Little Rock, AR 72203	1-800-482-5431 TTY: 1-800-285-1131	https://humanservices.arkansas.gov/divisions-shared-services/medical-

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
				8 am - 4:30 pm CST	services/helpful-information-for-clients/
California	Medi-Cal	P.O. Box 997413, MS 4400	Sacramento CA 95899-7413	1-800-541-5555 TTY: 1-800-896-2512 8 am - 5 pm PST	https://www.dhcs.ca.gov/individuals
Colorado	Health First Colorado (Department of Health Care Policy and Financing)	1570 Grant Street	Denver, CO 80203	1-800-221-3943 TTY: 711 7:30 a.m. - 5:15 p.m. MST	https://www.healthfirstcolorado.com/
Connecticut	Connecticut Department of Social Services	55 Farmington Avenue	Hartford, CT 06105-3730	1-800-842-1508 TTY: 1-800-842-4524 7:30 am - 4:00 pm EST	https://portal.ct.gov/dss
Delaware	Delaware Health and Social Services	1901 N. Du Pont Highway, Main Bldg.	New Castle, DE 19720	1-800-372-2022 TTY: 711 9 am - 8 pm EST	https://www.dhss.delaware.gov/dhss/dss/medicaid.html
District of Columbia	DC Department of Health Care Finance (DHCF)	441 4th St NW - 900S	Washington, DC 20001	1-202-442-5988 TTY: 711 8:15 am - 4:45 pm EST	https://dhcf.dc.gov/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Florida	Florida Agency for Health Care Administration	2727 Mahan Drive Mail Stop #8	Tallahassee, FL 32308	1-888-419-3456 TTY: 1-800-955-8771 8 am - 5 pm EST	https://ahca.myflorida.com/Medicaid/index.shtml
Georgia	Georgia Medicaid (Georgia Department of Community Health)	2 Peachtree Street NW	Atlanta, GA 30303	1-877-423-4746 TTY: 711 8 am - 5 pm EST	https://medicaid.georgia.gov/
Hawaii	Department of Human Services, Med-QUEST Division	1404 Kilauea Avenue	Hilo, HI 96720	1-800-316-8005 TTY: 1-800-603-1201 9:00 am - 4:30 pm HST	https://medquest.hawaii.gov/
Idaho	Idaho Department of Health and Welfare	150 Shoup Ave #19	Idaho Falls, ID 83402	1-877-456-1233 TTY: 711 8 am - 5 pm MST	https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx
Illinois	Illinois Department of Healthcare and Family Services	201 South Grand Avenue East	Springfield, IL 62763-0001	1-800-843-6154 TTY: 1-866-324-5553 8 am - 5 pm CST	https://www.illinois.gov/hfs/Pages/default.aspx

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Indiana	Office of Medicaid Policy and Planning (OMPP), Family and Social Services Administration (FSSA)	402 W. Washington Street P.O. Box 7083	Indianapolis, IN 46207-7083	1-800-457-8283 TTY: 711 8 am - 4:30 pm EST	https://www.in.gov/fssa/2408.htm
Iowa	Iowa Medicaid Enterprise	P.O. Box 36510	Des Moines, IA 50315	1-800-338-8366 TTY: 1-800-735-2942 8 am - 5 pm CST	https://dhs.iowa.gov/ime/members
Kansas	KanCare [Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF)]	1000 SW Jackson, Suite 900 N	Topeka, KS 66612	1-888-369-4777 TTY: 1-800-766-3777 8 am - 5 pm CST	https://www.kancare.ks.gov/
Kentucky	Kentucky Medicaid [Cabinet for Health and Family Services, Department for Medicaid Services (DMS)]	275 East Main Street 1E-B	Frankfort, KY 40621	1-800-372-2973 TTY: 1-800-627-4702 8 am - 4:30 pm EST	https://chfs.ky.gov/agencies/dms/Pages/default.aspx

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Louisiana	Department of Health & Hospitals	P.O. Box 91278	Baton Rouge, LA 70821	1-888-342-6207 TTY: 711 8 am - 4:30 pm CST	http://ldh.la.gov/index.cfm/subhome/1/n/10
Maine	MaineCare (Department of Health and Human Services)	Office of MaineCare Services, 11 State House Station	Augusta, ME 04333	1-800-977-6740 TTY: 711 8 am - 5 pm EST	https://www.maine.gov/dhhs/ofi/programs-services/health-care-assistance
Maryland	Department of Health and Mental Hygiene, Health Care Financing	201 West Preston Street	Baltimore, MD 21201	1-877- 463-3464 TTY: 1-800-735-2258 8:30 am - 5 pm EST	https://mmcp.health.maryland.gov/Pages/home.aspx
Massachusetts	MassHealth, Health and Human Services	One Ashburton Place 11th Floor	Boston, MA 02108	1-800-841-2900 TTY: 1-800-497-4648 8 am - 5 pm EST	https://www.mass.gov/topics/masshealth
Michigan	Michigan Department of Community Health (MDCH)	333 S. Grand Ave, P.O. Box 30195	Lansing, MI 48909	1-517-241-3740 TTY: 711 8 am - 5 pm EST	www.michigan.gov/medicaid

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Minnesota	Minnesota Department of Human Services	P.O. Box 64249	St. Paul, MN 55164	1-800-657-3739 TTY: 1-800-627-3529 8 am - 5 pm CST	https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/
Mississippi	Mississippi Division of Medicaid	550 High Street, Suite 1000	Jackson, MS 39201	1-800-421-2408 TTY: 711 8 am - 5 pm CST	https://medicaid.ms.gov/
Missouri	MO HealthNet (Medicaid) (Missouri Department of Social Services)	615 Howerton Court, P.O. Box 6500	Jefferson City, MO 65102-6500	1-800-348-6627 TTY: 1-800-735-2966 7 am - 6 pm CST	https://mydss.mo.gov/healthcare https://dss.mo.gov/mhd/index.htm
Montana	Montana Department of Public Health and Human Services (DPHHS)	111 North Sanders Street	Helena, MT 59601	1-800-362-8312 TTY: 711 8 am - 5 pm MST	https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices https://dphhs.mt.gov/
Nebraska	ACCESSNebraska (Department of Health and Human	301 Centennial Mall South, P.O. Box 95026	Lincoln, NE 68509	1-855-632-7633 TTY: 711 8 am - 5 pm CST	http://dhhs.ne.gov/pages/accessnebraska.aspx

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Services, Division of Medicaid and Long-Term Care)				
Nevada	Nevada Dept. of Health & Human Services, Division of Health Care Financing and Policy (DHCFP)	3416 Goni Rd – Ste D-132	Carson City, NV 89706	1-800-992-0900 TTY: 711 8 am - 5 pm PST	http://dhcfp.nv.gov/
New Hampshire	NH Medicaid [New Hampshire Department of Health and Human Services (DHHS)]	129 Pleasant Street	Concord, NH 03301-3857	1-800-852-3345 ext. 4344 TTY: 1-800-735-2964 8 am - 4:30 M-F EST	https://www.dhhs.nh.gov/programs-services/medicaid
New Jersey	Dept. of Human Services, Division of Medical Assistance & Health Services	Quakerbridge Plaza, P.O. Box 712	Trenton, NJ 08625-0712	1-800-356-1561 TTY: 1-877-294-4356 8 am - 5 pm EST	https://www.nj.gov/humanservices/dmahs/home/
New Mexico	New Mexico Human Services Department's Medical	P.O. Box 2348	Santa Fe, NM 87504	1-888-997-2583 TTY: 1-855-227-5485 8 am - 5 pm MST	https://www.hsd.state.nm.us/new-mexico-medicaid-state-plan/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Assistance Division (MAD)				
New York	New York State Department of Health	Corning Tower, Empire State Plaza	Albany, NY 12237	1-800-541-2831 TTY: 711 8 am - 5 pm EST	https://www.health.ny.gov/
North Carolina	NC Department of Health and Human Services, Division of Medical Assistance	1985 Umstead Dr.	Raleigh, NC 27603-2001	1-800-662-7030 TTY: 711 8 am - 5 pm EST	https://medicaid.ncdhhs.gov/beneficiaries
North Dakota	North Dakota Department of Human Services, Medical Services	600 E Boulevard Ave, Dept 325	Bismarck, ND 58505-0250	1-800-472-2622 TTY: 711 or Relay 800-366-6888 8 am - 5 pm CST	http://www.nd.gov/dhs/services/medicalserv/medicaid/
Ohio	Ohio Department Medicaid	50 West Town Street, Suite 400	Columbus, OH 43215	1-800-324-8680 TTY: 711 Monday - Friday 7 am - 8 pm Saturday 8am - 5pm	https://medicaid.ohio.gov/
Oklahoma	Oklahoma Department of Human Services, SoonerCare	4345 N. Lincoln Blvd.	Oklahoma City, OK 73105	1-800-987-7767 TTY: 711 8 am - 5 pm CST	https://www.okhca.org/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Oregon	Oregon Health Plan (OHP), Div. of Medical Assistance Programs (DMAP)	500 Summer Street NE, E-20	Salem, OR 97301-1079	1-800-273-0557 TTY: 711 8 am - 5 pm PST	https://www.oregon.gov/oha/hsd/ohp/Pages/index.aspx
Pennsylvania	Medical Assistance (Department of Health)	Health and Welfare Building 8th Floor West 625 Forster St.	Harrisburg, PA 17120	1-877-395-8930 TTY: 1-800-451-5886 8 am - 5 pm EST	https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
Rhode Island	Rhode Island Department of Human Services	57 Howard Avenue	Cranstom, RI 02920	1-855-840-4774 TTY: 711 Monday - Friday 8:30 a.m. - 3:30 p.m.	http://www.dhs.ri.gov/
South Carolina	South Carolina Department of Health and Human Services	SCDHHS P.O. Box 100101	Columbia, SC 29202	1-888-549-0820 TTY: 1-888-842-3620 8 am - 5 pm EST	https://www.scdhhs.gov/
South Dakota	South Dakota Medicaid (South Dakota Department of Social Services, The Division of Medical Services)	700 Governors Drive	Pierre, SD 57501	1-800-597-1603 8 am - 5 pm	https://dss.sd.gov/medicaid/
Tennessee	TennCare	310 Great Circle Rd	Nashville, TN 37243	1-800-342-3145 TTY: 711 8 am - 5 pm CST	https://www.tn.gov/tenncare/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Texas	Texas Health and Human Services Commission	North Austin Complex Building 4601 W. Guadalupe St. P.O. Box 13247	Austin, TX 78751-3146	211 TTY: 1-512-424-6597 8 am - 5 pm CST	https://hhs.texas.gov/services/health/medicaid-chip
Utah	Utah Department of Human Services	P.O. Box 143106	Salt Lake City, UT 84114	1-800-662-9651 TTY: 711 8 am - 5 pm MST	https://medicaid.utah.gov/
Vermont	Green Mountain Care [Department of Vermont Health Access (DVHA)]	280 State Drive	Waterbury, Vermont 05671	1-800-250-8427 TTY: 1-888-834-7898 7:45am - 4:30pm EST	https://www.greenmountaincare.org/health-plans/medicaid
Virginia	Department of Medical Assistance Services (DMAS)	600 East Broad Street	Richmond, VA 23219	1-804-786-7933 TTY: 1-800-343-0634 8 am - 5 pm MST	https://www.vdh.virginia.gov/disease-prevention/vamap/
Washington	Apple Health (Washington State Department of Social and Health Services)	626 8th Avenue SE Mailing Address: P.O. Box 45531	Olympia, WA 98501	1-877-501-2233 TTY: 711 8 am - 5 pm PST	https://www.hca.wa.gov/about-hca/programs-and-initiatives/apple-health-medicaid

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
West Virginia	Department of Health and Human Resources	350 Capitol Street, Room 251	Charleston, WV 25301	1-304-558-1700 TTY: 711 8 am - 5 pm EST	https://dhhr.wv.gov/bms/Pages/default.aspx
Wisconsin	Wisconsin Department of Health and Family Services	1 West Wilson Street	Madison, WI 53703	1-800-362-3002 or 608-266-1865 TTY: 711 8 am - 6 pm CST	https://www.dhs.wisconsin.gov/ https://www.dhs.wisconsin.gov/medicaid/index.htm
Wyoming	Wyoming Medicaid (Wyoming Department of Health, Healthcare Financing)	401 Hathaway Building	Cheyenne, WY 82002	1-866-571-0944 TTY: 711 8 am - 5 pm MST	https://health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-treatment-resources-for-patients/

State Pharmaceutical Assistance Programs (SPAPs)

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Colorado	Ryan White State Drug Assistance Program (SDAP)	CDPHE Care and Treatment Program ADAP-3800, 4300 Cherry Creek Drive South	Denver, CO 80246	1-303-692-2716 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://www.colorado.gov/pacific/cdphe/state-drug-assistance-program
Delaware	Chronic Renal Disease Program (CRDP)	Riverwalk, 253 NE Front Street	Milford, DE 19963	1-800-464-4357 or 1-302-424-7180	https://www.dhss.delaware.gov/dhss/dmma/crdprog.html
Idaho	Idaho HIV State Prescription Assistance Program (IDAGAP)	450 W. State Street, P.O. Box 83720	Boise, ID 83720-0036	1-208-334-5612 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
Indiana	Indiana HoosierRx	P.O. Box 6224	Indianapolis IN 46206-6224	1-866-267-4679 TTY: 711 Mon-Fri, 7 a.m. to 3 p.m.	https://www.in.gov/medicaid/members/26.htm
Maine	Maine Low Cost Drugs for the Elderly and Disabled Program Office of	242 State Street	Augusta, ME 04333	1-866-796-2463 TTY: 1-800-606-0215 Mon-Fri, 8 a.m. to 5 p.m.	https://q1medicare.com/PartD-SPAPMaineLowCstRxElderlyDisabled.php

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	MaineCare Services				
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP)	c/o Pool Administrators, 628 Hebron Avenue, Suite 502	Glastonbury, CT 06033	1-800-551-5995 TTY: 1-800-877-5156 Mon-Fri, 8 a.m. to 5 p.m.	http://marylandspdap.com/
Massachusetts	Massachusetts Prescription Advantage	P.O. Box 15153	Worcester, MA 01615-0153	1-800-243-4636 ext 2 TTY: 1-877-610-0241 Mon-Fri, 8 a.m. to 5 p.m.	https://www.mass.gov/prescription-drug-assistance
Montana	Montana Big Sky Rx Program	P.O. Box 202915	Helena, MT 59620-2915	1-866-369-1233 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky
Nevada	Nevada Senior Rx, Department of Health and Human Services	3320 W. Sahara Ave, Suite 100	Las Vegas, NV 89102	1-866-303-6323 (option 2) TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
New Jersey	New Jersey Department of Health and Senior Services Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)	P.O. Box 715	Trenton, NJ 08625-0715	1-800-792-9745 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://www.nj.gov/humanservices/doas/services/l-p/paad/
New York	New York Elderly Pharmaceutical Insurance Coverage Program (EPIC)	P.O. Box 15018	Albany, NY 12212-5018	1-800-332-3742 TTY: 1-800-290-9138 Mon-Fri, 8 a.m. to 5 p.m.	https://www.health.ny.gov/health_care/epic/
Pennsylvania	Pennsylvania Department of Aging PACE and PACENET Programs	P.O. Box 8806	Harrisburg, PA 17105-8806	1-800-225-7223 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)	Division of Elderly Affairs, 57 Howard Ave, Louis Pasteur Bldg, 2nd Floor	Cranston, RI 02920-3039	1-401-462-3000 TTY: 1-401-462-0740 Mon-Fri, 8 a.m. to 5 p.m.	https://www.payingforseniorcare.com/rhode-island/ripae

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Texas	Texas Kidney Health Care Program (KHC)	Kidney Health Care Mail Code 1938 P.O. Box 149030	Austin, TX 78714-9947	1-800-222-3986 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://hhs.texas.gov/services/health/kidney-health-care
Vermont	Department of Vermont Health Access Vermont VPharm	Application & Document Processing Center 280 State Drive	Waterbury, VT 05671-1500	1-800-250-8427 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://www.greenmountaincare.org/
Virginia	Virginia Medication Assistance Program (MAP)	Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street	Richmond, VA 23219	1-855-362-0658 TTY: 711	https://www.vdh.virginia.gov/disease-prevention/vamap/
Washington	Washington State Health Insurance State Pharmacy Assistance Program	P.O. Box 1090	Great Bend, KS, 67530	1-800-877-5187 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m. Pacific	https://www.insurance.wa.gov/washington-state-health-insurance-pool-wship
Wisconsin	Wisconsin Senior Care	1 West Wilson Street	Madison, WI 53703	1-608-266-1865 TTY: 1-800-947-3529 or 711 Mon-Fri, 8 a.m. to 5 p.m.	https://www.dhs.wisconsin.gov/seniorcare/index.htm

AIDS Drug Assistance Programs (ADAP)

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	Alabama Department of Public Health AIDS Drug Assistance Program HIV/AIDS Division	The RSA Tower, 201 Monroe Street, Suite 1400	Montgomery, AL 36104-3773	1-866-574-9964 TTY: 711	http://www.alabamapublichealth.gov/hiv/adap.html
Alaska	Alaska Aids Assistance Association	1057 W. Fireweed Lane, Suite 102	Anchorage, AK 99503	1-800-478-AIDS TTY: 711	https://www.alaskanaids.org/
Arizona	Arizona Department of Health Services (ADHS) Office of Disease Integration and Services	150 N. 18th Avenue	Phoenix, AZ 85007	1-800-334-1540 TTY: 711	https://www.azdhs.gov/
Arkansas	Arkansas HIV/STD/ Hepatitis C ADAP Division	4815 W. Markham Street Slot 33	Little Rock, AR 72205	1-501-661-2408 TTY: 711	http://adap.directory/arkansas
California	California Department of Public Health Office of AIDS	Office of AIDS Center for Infectious Diseases California	Sacramento, CA 95899-7426	1-916-558-1784 TTY: 711	https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
		Department of Public Health, MS 7700 P.O. Box 997426			
Colorado	Ryan White State Drug Assistance Program (SDAP)	CDPHE Care and Treatment Program ADAP-3800, 4300 Cherry Creek Drive South	Denver, CO 80246	1-303-692-2716 TTY: 711 Monday-Friday 8 a.m. to 5 p.m.	https://cdphe.colorado.gov/state-drug-assistance-program
Connecticut	Connecticut AIDS Drug Assistance Program (CADAP)	State of Connecticut Department of Public Health c/o Magellan P.O. Box 13001	Albany, NY 11212-3001	1-800-424-3310 TTY: 1-800-842-4524	https://portal.ct.gov/DSS/Health-And-Home-Care/CADAP/Connecticut-AIDS-Drug-Assistance-Program-CADAP
Delaware	Ryan White Program (Delaware AIDS Drug Assistance	540 S. DuPont Highway	Dover, DE 19901	1-302-744-1000 TTY: 711	https://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html
District of Columbia	District of Columbia AIDS Drug Assistance Program (DC ADAP)	899 N. Capitol Street NE	Washington, DC 20002	1-202-671-4900 TTY: 711	https://dchealth.dc.gov/DC-ADAP

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Florida	Florida AIDS Drug Assistance Program	HIV/AIDS Section 4052 Bald Cypress Way	Tallahassee, FL 32399	1-850-245-4422 TTY: 711	https://www.floridahealth.gov/diseases-and-conditions/aids/adap/adap-enrollment.html
Georgia	Georgia Department of Public Health, Health Protection, Office of HIV/AIDS	2 Peachtree Street, NW, 15th Floor	Atlanta, GA 30303-3186	404-656-9805 TTY: 711	https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	Harm Reduction Services Branch	3627 Kilauea Avenue, Suite 306	Honolulu, HI 96816	1-808-733-9010 TTY: 711	https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-case-management/
Idaho	Idaho HIV State Prescription Assistance Program (IDAGAP)	450 W. State Street, P.O. Box 83720	Boise, ID 83720-0036	1-208-334-5612 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	https://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Illinois	Illinois Department of Public Health AIDS Drug Assistance Program	525 W. Jefferson Street, First Floor	Springfield, IL 62761	1-217-782-4977 TTY: 1-800-547-0466	https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services.html
Indiana	Indiana State Department of Health and Human Services Division HIV Medical Services Program	2 N Meridian St Suite 6C	Indianapolis, IN 46204	1-866-588-4948, Option 1 TTY: 711	https://www.in.gov/health/hiv-std-viral-hepatitis/
Iowa	Iowa Department of Public Health Bureau of HIV, STD and Hepatitis	321 E. 12th Street	Des Moines, IA, 50319-0075	515-204-3746 TTY: 711 or 1-800-735-2942	https://hhs.iowa.gov/public-health/hiv-stis-and-hepatitis
Kansas	Kansas AIDS Drug Assistance Program	1000 SW Jackson Street, Suite 210	Topeka, KS 66612	1-785-296-6174 TTY: 711	https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program
Kentucky	Kentucky AIDS Drug Assistance Program (KADAP)	275 E. Main St., HS2E-C	Frankfort, KY 40621	1-800-420-7431 TTY: 711	https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Louisiana	Louisiana Health Access Program (LAHAP)	1450 Poydras Street, Suite 2136	New Orleans, LA 70112	1-504-568-7474 TTY: 711	https://www.lahap.org/
Maine	Maine AIDS Drug Assistance Program	286 Water Street, State House Station 11	Augusta, ME 04333	1-207-287-3747 TTY: 711	https://adap.directory/maine
Maryland	Maryland AIDS Drug Assistance Program (MADAP)	201 W. Preston Street	Baltimore, MD 21201-2399	1-800-205-6308 TTY: 711	https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
Massachusetts	Massachusetts HIV Drug Assistance Program (HDAP)	Schrafft's Center, 529 Main Street, Suite 301	Charlestown, MA 02129	1-800-228-2714 TTY: 711	https://crine.org/hdap/
Michigan	Michigan HIV/AIDS Drug Assistance Program (MIDAP)	109 Michigan Avenue, 9th Floor	Lansing, MI 48913	1-888-826-6565 TTY: 711	https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program
Minnesota	Minnesota HIV/ AIDS Program Department of Human Services	HIV/AIDS Programs Department of Human Services, P.O. Box 64972	St. Paul, MN 55164-0972	1-800-657-3761 TTY: 711 or 1-800-627-3529	https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					services/medications.jsp
Mississippi	Mississippi AIDS Drug Assistance Program	570 E. Woodrow Wilson Drive	Jackson, MS 39216	1-888-343-7373 TTY: 711	https://msdh.ms.gov/msdhsite/_static/14,13047,150.html
Missouri	Missouri AIDS Drug Assistance Program	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services, P.O. Box 570	Jefferson City, MO 65102	1-573-751-6439 TTY: 711	https://health.mo.gov/living/healthcondiseases/communicable/hivaids/
Montana	Montana Ryan White HIV Care Program (Montana AIDS Drug Assistance Program, DPHHS)	Cogswell Building Room C-211, 1400 Broadway	Helena, MT 59620	1-406-444-3565 TTY: 711	https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	Nebraska AIDS Drug Assistance Program	P.O. Box 95044, 301 Centennial Mall South	Lincoln, NE 68509	1-402-559-4673 TTY: 711	https://adap.directory/nebraska

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Nevada	Nevada AIDS Drug Assistance Program	Office of HIV/AIDS 4126 Technology Way, Suite 200	Carson City, NV 89706	1-775-684-5928 TTY: 711	http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/
New Hampshire	New Hampshire Department of Health & Human Services	New Hampshire Department of Health and Human Services 129 Pleasant Stree	Concord, NH 03301-3852	1-800-852-3345 ext 4502 TTY: 1-800-735-2964	https://www.dhhs.nh.gov/
New Jersey	New Jersey Department of Health	P.O. Box 360	Trenton, NJ 08625-0360	1-800-624-2377 TTY: 711	https://www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml
New Mexico	New Mexico Department of Health HIV/AIDS Services Program	1190 St. Francis Drive, Suite S1200	Santa Fe, NM 87502	1-505-827-2435 TTY: 711	https://www.nmhealth.org/about/phd/idb/hats/
New York	New York HIV Uninsured Care Programs	Empire Station, P.O. Box 2052	Albany, NY 12220-0052	1-800-542-2437 TTY: 1-518-459-0121	https://www.health.ny.gov/diseases/aids/general/resources/adap/

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
North Carolina	North Carolina Department of Health and Human Services	Communicable Disease Branch, Epidemiology Section Division of Public Health, N.C. Dept of Health and Human Services 1902 Mail Service Center	Raleigh, NC 27699-1902	1-919-733-3419 TTY: 711	https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	North Dakota Department of Health HIV/AIDS Program	North Dakota Department of Health Division of Disease Control, 2635 East Main Ave	Bismarck, ND 58505	1-800-472-2180 TTY: 711	https://www.ndhealth.gov/hiv/RyanWhite/
Ohio	Ohio AIDS Drug Assistance Program	246 N. High Street	Columbus, OH 43215	1-614-995-5599 TTY: 711	https://odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
Oklahoma	Oklahoma AIDS Drug Assistance Program	1000 NE Tenth & Stonewall, Mail Drop 0308	Oklahoma City, OK 73117-1299	405-271-4000 TTY: 711	https://adap.directory/oklahoma

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Oregon	Oregon CAREAssist Program	800 NE Oregon Street, Suite 1105	Portland, OR 97232	1-971-673-0144 TTY: 711	https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
Pennsylvania	Pennsylvania Department of Health	Pennsylvania Department of Health, Special Pharmaceutical Benefits Program, P.O. Box 8808	Harrisburg, PA 17105-8808	1-800-922-9384 TTY: 711	https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx
Rhode Island	Rhode Island Aids Drug Assistance Program	3 Capitol Hill	Providence, RI 02908	1-401-222-5960 TTY: 711	https://health.ri.gov/diseases/hivaids/about/stayinghealthy/
South Carolina	South Carolina AIDS Drug Assistance Program	2600 Bull Street	Columbia, SC 29201	1-800-322-2437 TTY: 711	https://scdhec.gov/aids-drug-assistance-program
South Dakota	Ryan White Part B CARE Program, South Dakota Department of Health	615 E. 4th Street	Pierre, SD 57501-1700	1-800-592-1861 TTY: 711	https://doh.sd.gov/topics/diseases/infectious/reportable-communicable-diseases/hivaids/

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					ryan-white-part-b-program/
Tennessee	Tennessee HIV Drug Assistance Program (HDAP)	Tennessee Department of Health HIV/STD Program Administrative Offices: 4th Floor, Andrew Johnson Tower, 710 James Robertson Pkwy	Nashville, TN 37243	1-800-525-2437 TTY: 711	https://adap.directory/tennessee
Texas	Texas HIV/STD Medication Program (THMP)	Texas HIV Medication Program ATTN: MSJA, MC 1873, Post Office Box 149347	Austin, TX 78714-9347	1-800-255-1090 TTY: 711	https://www.dshs.state.tx.us/hivstd/meds/default.shtm
Utah	Utah AIDS Drug Assistance Program	288 North 1460 West, P.O. Box 142104	Salt Lake City, UT 84114-2104	1-801-538-6191 TTY: 711	https://adap.directory/utah
Vermont	Vermont Medication Assistance	AIDS Medication Assistance Program, 108 Cherry Street	Burlington, VT 05402-0070	1-800-464-4343 TTY: 711	https://www.healthvermont.gov/disease-

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Program (VMAP)				control/hiv/hiv-care
Virginia	Virginia Department of Health (VDH) AIDS Drug Assistance Program	Virginia Department of Health, HCS Unit, 1st Floor James Madison Building, 109 Governor Street	Richmond, VA 23219	1-855-362-0658 TTY: 711	https://www.vdh.virginia.gov/disease-prevention/vamap/
Washington	Washington State's AIDS Drug Assistance	P.O. Box 47841	Olympia, WA, 98504-7841	1-877-376-9316 TTY: 711	https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP
West Virginia	West Virginia AIDS Drug Assistance Program	350 Capitol Street,Room 125	Charleston, WV 25301	1-800-642-8244 TTY: 711	https://oeps.wv.gov/rwp/pages/default.aspx
Wisconsin	Wisconsin AIDS/ HIV Drug Assistance Program	1 West Wilson Street	Madison, WI 53703	1-608-266-1865 TTY: 711 or 1-800-947-3529	https://www.dhs.wisconsin.gov/hiv/adap.htm
Wyoming	Wyoming Department of Health AIDS Drug Assistance Program	401 Hathaway Building	Cheyenne, WY 82002	1-307-777-5856 TTY: 711	https://health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					program/hiv-treatment-resources-for-patients/

Blue Cross Group MedicareRx (PDP) Customer Service

Method	Customer Service – Contact Information
CALL	1-877-838-3833 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. We are open 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
FAX	1-855-297-4245
WRITE	Customer Service P.O. Box 3897 Scranton, PA 18505

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

You can find contact information for the State Health Insurance Assistance Program (SHIP) in your state in the appendix in the back of this document.

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